Senate

General Assembly

File No. 442

January Session, 2001

Substitute Senate Bill No. 177

Senate, April 25, 2001

The Committee on Public Health reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING COLLECTIONS BY HEALTH CARE PROVIDERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

(NEW) No health care provider may commence collection proceedings against any patient for unpaid fees for services rendered to such patient: (1) If such patient is an insured under a health insurance policy or an enrollee under a managed care plan and files an appeal or grievance pursuant to the internal appeal or grievance process provided by the insurer, managed care organization or utilization review company or the external appeal process established under section 38a-478n of the general statutes; and (2) during the period commencing on the date such appeal or grievance is filed and ending ninety calendar days after such date or on the date such appeal or grievance is denied, whichever is later. Such patient shall furnish the health care provider with proof of the filing of such appeal or grievance.

PH *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: None

Affected Agencies: None

Municipal Impact: None

Explanation

State Impact:

The bill specifies that no health care provider may commence collection proceedings against any patient for unpaid fees for services rendered to such patient if the patient is enrolled in a managed care plan and files an appeal or grievance. A health care provider shall not commence collection proceedings if services provided to the insured are subject to review by a utilization review company or the insured has initiated an external appeals process with the Department of Insurance. There is no fiscal impact to the state as a result of this bill.

OLR Bill Analysis
sSB 177

AN ACT CONCERNING COLLECTIONS BY HEALTH CARE PROVIDERS.

SUMMARY:
This bill prohibits health care providers from starting collection proceedings against insured patients for unpaid fees under certain conditions. The patient must be insured under a health insurance policy or enrolled in a managed care plan and have filed an appeal or grievance according to the internal appeal or grievance procedure of the insurer, managed care organization, or utilization review company or under the external appeals process established by law.

The bill also prohibits the start of collection activity for 90 days after the appeal or grievance is filed, or until the appeal or grievance is denied, whichever is later.

EFFECTIVE DATE: October 1, 2001

BACKGROUND

Internal Grievance Procedure

By law, each managed care organization must have an internal complaint and grievance procedure so that an enrollee can seek review and timely resolution of a complaint against a plan's action or inaction. Enrollees must be informed of the grievance procedure at initial enrollment and at least annually afterwards. They must be informed when a decision is made not to certify an admission, service, or stay extension. By law, each review must be resolved within 60 days of the time the enrollee initiated the complaint unless he requests an extension.

Utilization Review

Utilization review is a process to determine the medical necessity and appropriate level of care provided to individuals and to control costs by requiring patients and their providers to get approval for certain admissions and procedures. The Insurance Department licenses utilization review companies.

External Appeals

The law allows an enrollee, or a provider acting for him, who has exhausted all internal appeals procedures of a managed care organization or a utilization review company, to appeal to the insurance commissioner any decision concerning the necessity and appropriateness of health care services or resources. The law establishes the procedures for filing such an appeal.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 25 Nay 0